Uniform Dental Plan 2011

Washington Public Employees and Retirees

# Uniform Dental Plan 2011

A preferred provider plan, self-insured by the state of Washington

Administered by:

DELTA DENTAL®

Washington Dental Service

Washington Dental Service is a member of the Delta Dental Plans Association

Published under the direction of the Washington State Health Care Authority

## SAVE THIS BOOKLET FOR REFERENCE

This booklet explains benefit provisions that are specific to a dental plan administered by the Washington State Health Care Authority. The booklet, which explains program eligibility and general provisions, constitutes the certificate of coverage for enrollees in this dental plan. This certificate of coverage replaces and supersedes any and all previous certificates.

It is your responsibility to be informed about your benefits. To avoid penalty or loss of benefits, please note all plan predetermination requirements, service area restrictions and benefit limitations. If provisions within this booklet are inconsistent with any federal or state statute or rules, the language of the statute or rule will have precedence over that contained in this publication.

This booklet was compiled by the Washington State Health Care Authority, 676 Woodland Square Loop S.E., P.O. Box 42682, Olympia, Washington 98504-2682. If you have questions on the provisions contained in this booklet, please contact the dental plan.

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# UNIFORM DENTAL PLAN

## Self-Insured by the State of Washington

FOR BENEFITS AVAILABLE BEGINNING JANUARY 1, 2011

**Administered by**
**Washington Dental Service**
P.O. Box 75983
Seattle, Washington 98175-0983
206-522-3344 or 1-800-537-3406
**www.DeltaDentalWA.com**

# Certificate of Coverage

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## Welcome to the Uniform Dental Plan and Washington Dental Service (WDS).

Washington Dental Service began providing dental benefits coverage in 1954 and has been providing coverage to state of Washington employees through the Uniform Dental Plan since 1988. WDS is now the largest dental benefits provider in Washington state, serving approximately 2 million people nationwide.

In 1994, the Uniform Dental Plan introduced the WDS preferred provider (PPO) program. This program continues to provide enrollees with the freedom to choose any dentist, and it gives subscribers the opportunity to receive a higher level of coverage by receiving treatment from those dentists who participate in the Uniform Dental Plan (WDS's Delta Dental PPO plan). Today, more than 60 percent of the dentists in Washington participate in the Delta Dental PPO program.

Washington Dental Service works closely with the dental profession to design dental plans that promote high-quality treatment along the most cost-effective path. As any dental care professional will attest, the key to having good oral health and avoiding dental problems is prevention. The Uniform Dental Plan and all WDS programs are structured to encourage regular dental visits and early treatment of dental problems before they become more costly.

Washington Dental Service is committed to providing the highest quality customer service to all enrollees. WDS's dedicated customer service representatives are available toll-free to enrollees from 8 a.m. to 5 p.m., Monday through Friday. You can also access information through our automated inquiry system with a touch-tone phone by entering your Social Security number.

Thank you for enrolling in the Uniform Dental Plan. We are happy to be serving 268,165 enrollees.

To obtain services, inform your dentist that you are covered by the Uniform Dental Plan, WDS program number **03000**.

## Retiree Participation

Retirees must be enrolled in a medical plan to enroll in the dental plan. If they enroll in the medical and dental plans, they must enroll the same eligible dependents under both plans. Once enrolled in the medical and dental package, retirees cannot change to "medical-only" for at least two years. The two-year requirement does not apply to retirees whose medical and dental coverage is terminated due to the retiree's return to employment and subsequent enrollment in active group coverage, including spouse's re-employment.

## Terms Used in This Booklet

**Appeal** — An appeal is a written or oral request from an enrollee or, if authorized by the enrollee, the enrollee's representative to change a previous decision made by WDS concerning: a) access to dental care benefits, including an adverse determination made pursuant to utilization review; b) claims handling, payment, or reimbursement for dental care and services; c) matters pertaining to the contractual relationship between an enrollee and WDS or d) other matters as specifically required by state law or regulation.

**Amalgam** — A mostly silver filling often used to restore decayed teeth.

**Caries** — Decay. A disease process initiated by bacterially produced acids on the tooth surface.

**Coinsurance** — WDS will pay a predetermined percentage of the cost of your treatment (see Reimbursement Levels for Allowable Benefits under the Summary of Benefits) and you are responsible for paying the balance. What you pay is called the coinsurance. It is paid even after a deductible is reached.

**Washington Dental Service/Delta Dental Participating Dentists** — If you select a dentist who is a WDS participating dentist, that dentist has agreed to provide treatment for eligible persons covered by WDS programs according to the provisions of his or her participating dentist contract. You will not have to hassle with sending in claim forms. WDS participating dentists complete claim forms and submit them directly to WDS. They receive payment directly from WDS. You will not be charged for more than the pre-approved fee that the WDS participating dentist has filed with us. You will be responsible only for stated coinsurance (see Coinsurance), deductibles, any amount over the plan maximum and for any elective care you choose to receive outside the covered benefits.

**Delta Dental PPO Dentists** — Delta Dental PPO dentists must be WDS/Delta Dental participating dentists in order to participate in the Delta Dental PPO network. Delta Dental PPO dentists receive payment based on their Delta Dental PPO filed fees at the percentage levels listed on your plan for Delta Dental PPO dentists. Patients are responsible only for percentage coinsurance up to the Delta Dental PPO filed fees. Delta Dental PPO is a point-of-service plan, meaning that you can choose any dentist — in or out of the Delta Dental PPO network — at the time you need treatment. However, if you select a dentist who is a Delta Dental PPO dentist, your benefits will likely be paid at a higher level and your out-of-pocket expenses may be lower.

**Delta Dental Premier® Dentists (non-PPO)** — Delta Dental Premier® dentists also have contracts with WDS, but they are not part of the Delta Dental PPO network. Delta Dental Premier® dentists will submit claim form for you and receive payment directly from WDS. Their payments will be based on their pre-approved fees with WDS. They also cannot charge you more than these fees. You will be responsible only for stated deductibles, coinsurance and/or amounts in excess of the program maximum.

**Nonparticipating Dentists in Washington State** — If you select a dentist who is not a WDS participating dentist, you are responsible for having your dentist complete and sign a claim form. We accept any American Dental Association-approved claim form that your dentist may provide. You can also download claim forms from our Web site at www.DeltaDentalWA.com. It is up to you to ensure that the claim is sent to WDS. Payment for services performed by a nonparticipating dentist will be based on actual charges or WDS's maximum allowable fees, whichever is less. You will be responsible for any balance remaining. Please be aware that WDS has no authority over nonparticipating dentists' charges or billing practices.

**Out-of-State Dentists** — If you receive treatment from a dentist outside Washington state, you are responsible for having the dentist complete and sign a claim form. It is also up to you to ensure that the claim is sent to WDS. Payment will be based upon actual charges or WDS's maximum allowable fees for participating dentists, whichever is less.

**Dental Emergency** — The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a dental condition exists that requires immediate dental attention, if failure to provide dental attention would result in serious impairment to oral functions or serious dysfunction of the mouth or teeth, or would place the person's oral health in serious jeopardy.

**Dental Necessity** — A service is "dentally necessary" if it is recommended by your treating provider and if all of the following conditions are met.

Necessary vs. Not Covered Treatment — You and your provider should discuss which services may not be covered dental benefits. Not all necessary treatment is covered, and there may be additional charges. The majority of required dental services are covered by your plan. However, there are certain treatments that remain the responsibility of the patient.

1. The purpose of the service, supply or intervention is to treat a dental condition;
2. It is the appropriate level of service, supply or intervention considering the potential benefits and harm to the patient;
3. The level of service, supply or intervention is known to be effective in improving health outcomes;
4. The level of service, supply or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention; and
5. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.
    - A health "intervention" is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a dental condition (i.e., disease, illness, injury, genetic or congenital defect or a biological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of "dental necessity," a health intervention means not only the intervention itself, but also the dental condition and patient indications for which it is being applied.

- “Effective” means that the intervention, supply or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- An intervention, supply or level of service may be dentally indicated, yet not be a covered benefit or meet the standards of this definition of “dental necessity.” UDP may choose to cover interventions, supplies, or services that do not meet this definition of “dental necessity”; however, UDP is not required to do so.
- “Treating provider” means a health care provider who has personally evaluated the patient.
- “Health outcomes” are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.
- An intervention is considered to be new if it is not yet in widespread use for the dental condition and patient indications being considered.
- “New interventions” for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion. (See “existing interventions” below.)
- “Scientific evidence” consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.
- For “existing interventions,” the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of “dental necessity.” If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence.

  Existing interventions can meet UDP's definition of “dental necessity” in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.
- A level of service, supply or intervention is considered “cost effective” if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

**Dentist** — A licensed dentist legally authorized to practice dentistry at the time, and in the place, services are performed. This Plan provides for covered services only if those services are performed by or under direction of a licensed dentist or other WDS-approved licensed professional. A “licensed dentist” does not mean a dental mechanic or any other type of dental technician.

**Endodontics** — The diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

**Enrollee** — The subscriber or a covered dependent enrolled in this plan

**Experimental or Investigative** — A service or supply that is determined by the Uniform Dental Plan to meet any one of the following criteria. If any of these situations are met, the service or supply is considered experimental and/or investigative, and benefits will not be provided.

1. It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA), and such approval has not been granted on the date it is furnished.
2. The provider has not demonstrated proficiency in the service, based on knowledge, training, experience, and treatment outcomes.

3. Reliable evidence shows the service is the subject of ongoing clinical trials to determine its safety or effectiveness.
4. Reliable evidence has shown the service is not as safe or effective for a particular dental condition compared to other generally available services and that it poses a significant risk to the enrollee's health or safety.

Reliable evidence means only published reports and articles in authoritative dental and scientific literature, scientific results of the provider's written protocols or scientific data from another provider studying the same service.

The documentation used to establish the plan criteria will be made available for enrollees to examine at the office of the Uniform Dental Plan, if enrollees send a written request.

If WDS determines that a service is experimental or investigative, and therefore not covered, the enrollee may appeal the decision. Uniform Dental Plan will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with the enrollee's informed written consent.

**Group** — The employer or entity that is contracting for dental benefits for its employees.

**HCA** — The Health Care Authority.

**Licensed Professional** — An individual legally authorized to perform services as defined in his or her license. Licensed professional includes, but is not limited to, denturist, hygienist and radiology technician.

**Not a paid covered benefit** — Any dental procedure which, under some circumstances, would be covered by WDS but is not covered under other conditions, examples of which are listed in Benefits Covered by Your Program.

**Occlusal Guard** — A removable dental appliance — sometimes called a nightguard — that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An occlusal guard (nightguard) is typically used at night.

**Orthodontics** — Diagnosis, prevention and treatment of irregularities in tooth and jaw alignment and function, frequently involving braces.

**Periodontics** — The diagnosis, prevention and treatment of diseases of gums and the bone that supports teeth.

**Plan or UDP** — The Uniform Dental Plan.

**Plan Designated Facility or Provider** — Administered by Washington Dental Service.

**Prosthodontics** — The replacement of missing teeth by artificial means such as bridges and dentures.

**Resin-based Composite** — Tooth-colored filling, made of a combination of materials, used to restore teeth.

**Specialist** — A licensed dentist who has successfully completed an educational program accredited by the Commission of Dental Accreditation, two or more years in length, as specified by the Council on Dental Education or holds a diploma from an American Dental Association-recognized certifying board.

**Subscriber** — Employee or retiree eligible to enroll in this dental plan.

**WDS** — Washington Dental Service, a not-for-profit dental service corporation.

## Service Area

The Uniform Dental Plan preferred provider organization (PPO) service area is all of Washington state. If enrollees need assistance in locating PPO providers in their areas, they should contact the plan.

The out-of-PPO service area is any location outside of Washington state. If enrollees are treated by out-of-state dentists, they will be responsible for having the dentists complete and sign claim forms. It will also be up to them to ensure that the claims are sent to WDS. For covered services, the plan will pay either the dentists' actual charges or the maximum allowable fee normally paid to WDS participating dentists for the same services, whichever is less.

## Uniform Dental Plan Providers

Washington Dental Service has participating dentist contracts with nearly 3,400 licensed dentists in the state of Washington. Under the Uniform Dental Plan, enrollees have the option of seeking care from any licensed dentist, whether or not the dentist is a member of WDS. However, their benefits may be paid at a higher level and their out-of-pocket costs will likely be lower if they see WDS participating PPO dentists. This is because participating PPO dentists agree to provide care based on a lower average fee schedule.

Participating dentists submit claim forms to WDS and receive payments directly from WDS. Enrollees are responsible only for stated deductibles, copayments and/or amounts in excess of the program maximum.

More than 60% of WDS participating dentists participate in the Uniform Dental Plan/Delta Dental PPO network. Enrollees are not required to choose a dentist at enrollment and are free to choose a different dentist each time they seek treatment.

If enrollees need assistance locating PPO dentists in their areas, or have questions about benefits or payment of claims, they should call the Uniform Dental Plan customer service team at (800) 537-3406. Customer service representatives are available weekdays from 8 a.m. to 5 p.m., Monday through Friday. In addition you can obtain a current list of WDS dentists by going to our Web site at www.DeltaDentalWa.com. Go to Looking for a Dentist and click on Read More. This will bring up the WDS Find a Dentist directory. Be sure to click on the Delta Dental PPO plan and follow the prompts.

Enrollees may also seek treatment from Delta Dental Premier® dentists, who are members of WDS's traditional fee-for-service plan. Their payments, however, are likely to be higher than if they see PPO dentists. Delta Dental Premier® dentists also submit claims forms and receive payments directly from WDS. Enrollees are responsible only for stated deductibles, copayments and/or amounts in excess of the program maximum.

Nonparticipating dentists have not contracted with WDS. Payment for services performed by a nonparticipating dentist is based upon enrollees' dentist's actual charges or WDS's maximum allowable fees for nonparticipating dentists, whichever is less. If the enrollee sees a nonparticipating dentist, he or she will be responsible for having the dentist complete and sign claim forms. It will also be up to the enrollee to ensure that the claims are sent to WDS.

## Deductible

Your program has a $50 deductible per eligible person each benefit period. This means that from the first payment or payments made for covered dental benefits, a deduction of $50 is made. Once each eligible person has satisfied the deductible during the period, no further deduction will apply to that eligible person until the next period. The maximum deductible per family each benefit period is $150. This means that the maximum amount that will be deducted for a family, regardless of the number of eligible persons, will be $150. Once a family has satisfied the maximum deductible amount during the period, no further deduction will apply to that family until the next succeeding period. The deductible does not apply to Class I covered dental benefits or Orthodontic Benefits.

## Maximum Annual Plan Payment

For your program, the maximum amount payable by WDS/Delta Dental for Class I, II and III covered dental benefits per eligible person is $1,750 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the program maximum based on the incurred date.

## Lifetime Benefit Maximums

The lifetime maximum amounts payable per eligible person for covered dental benefits are:

1. Orthodontia: $1,750
2. Temporomandibular joint (TMJ) treatment: $500
3. Orthognathic surgery: $5,000

## Specialty Services

Specialty treatment is a covered benefit under the Uniform Dental Plan. As with all dental treatment, enrollees will receive a higher level of benefits if they obtain treatment from a PPO dentist. Enrollees may want to ask their dentists to refer them to PPO specialists in the event they need specialty care. PPO specialists are listed in the Uniform Dental Plan provider directory, or enrollees may contact the Uniform Dental Plan customer service team at (800) 537-3406.

## Benefit Levels for Uniform Dental Plan

| SERVICES | PPO Dentists in Washington State | Out of State | Non-PPO Dentist in Washington State |
|---|---|---|---|
| **Diagnostic/preventive** | 100% | 90% | 80% |
| **Restorative fillings** | 80% | 80% | 70% |
| **Oral surgery** | 80% | 80% | 70% |
| **Periodontic services** | 80% | 80% | 70% |
| **Endodontic services** | 80% | 80% | 70% |
| **Restorative crowns** | 50% | 50% | 40% |
| **Prosthodontic (dentures and bridges)** | 50% | 50% | 40% |
| **Orthodontic (to lifetime maximum plan payment of $1,750)** | 50% | 50% | 50% |
| **Non-surgical TMJ (to lifetime maximum plan payment of $500)** | 70% | 70% | 70% |
| **Orthognathic (to lifetime maximum plan payment of $5,000)** | 70% | 70% | 70% |

## Emergency Care

Emergency care is defined as treatment for relief of pain resulting from an unexpected condition that requires immediate dental treatment. Enrollees should first contact their dentists. If the enrollee's PPO dentist is not available, he or she should call the Uniform Dental Plan customer service team at (800) 537-3406. WDS will find a PPO dentist who can treat the enrollee or will approve treatment from a non-PPO dentist and will pay benefits at the PPO benefit level. If an emergency occurs after regular office hours, enrollees should first contact their PPO dentists. If the enrollee's dentist is not available, enrollees may seek treatment from any dentist for pain relief. If a PPO dentist is not available, the enrollee's claim from a non-PPO dentist will be paid at the PPO benefit level.

Claims for emergency treatment received by a non-PPO dentist when the enrollee's regular PPO dentist is not available must be sent with a written explanation to:

Send your claim to:

Washington Dental Service
Customer Service
Post Office Box 75983
Seattle, WA 98175-0983

Emergencies outside the PPO service area are paid as any other treatment received outside the service area.

## Urgent Care

“Urgent care” means a condition occurring suddenly and unexpectedly or an exacerbation of an existing condition that requires care and treatment as soon as possible to prevent the condition from becoming an emergency condition. If enrollees are within 50 miles of their dentists, they should first contact their dentists. If the PPO dentist is not available, the enrollee should call the plan.

If enrollees are more than 50 miles from their dentists, they should seek treatment from any dentist for screening and adequate stabilization to allow for further treatment from their dentists at a later time.

Claims for urgent care treatment received by a non-PPO dentist when the enrollee’s regular PPO dentist is not available must be sent with a written explanation to:

Send your claim to:

Washington Dental Service
Customer Service
Post Office Box 75983
Seattle, WA 98175-0983

Services for urgent care outside the PPO service area are paid as any other treatment received outside the service area.

## Predetermination of Benefits

If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, sometimes called a “predetermination of benefits.” This will allow you to know in advance what procedures may be covered, the amount WDS may pay and your expected financial responsibility.

A predetermination is not an authorization for services but a notification of Covered Dental Benefits available at the time the predetermination is made and is not a guarantee of payment.

A predetermination of benefits is valid for 12 months but in the event your benefits are terminated and you are no longer eligible, the predetermination is voided. WDS will make payments based on your available benefits (maximum, deductible and other limitations as described in your benefits booklet) and the current plan provisions when the treatment is provided.

## Second Opinion

To determine covered benefits for certain treatments, the Uniform Dental Plan may require a patient to obtain a second opinion from a WDS-appointed consultant. The Uniform Dental Plan will pay 100% of the charges incurred for the second opinion.

## Covered Dental Benefits, Limitations and Exclusions

The following covered dental benefits are subject to the limitations and exclusions contained in this booklet. Such benefits (as defined) are available only when rendered by a licensed dentist or other WDS-approved licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and WDS. The amounts payable for covered dental benefits are as stated above. Claims for services must be submitted within 12 months of the completion of treatment.

## Class I Benefits

### Diagnostic Services

#### Covered Dental Benefits

- Routine examination (periodic oral evaluation)
- Comprehensive oral evaluation

- X-rays
- Emergency examination
- Specialist examination performed by a Specialist in an American Dental Association-recognized specialty.

**Limitations**

- Routine examination is covered twice in a calendar year
- Comprehensive oral evaluation is covered once in a three-year period from the date of service per Eligible Person per dentist. Additional comprehensive oral evaluations are allowed as routine examinations.
  - Comprehensive oral evaluations are considered as one of the two covered examinations per benefit period.
- A complete series (any number or combination of intraoral X-rays, billed for same date of service, that equals or exceeds the allowed fee for a complete series is considered a complete series for payment purposes) or panoramic X-ray is covered once every five years from the date of service.
- Supplementary bitewing X-rays are covered once in a calendar year.

**Exclusions**

- Consultations or elective second opinions.
- Study models and charges for the review of a proposed treatment plan.

## Preventive Services

**Covered Dental Benefits**

- Prophylaxis (cleaning)
- Periodontal maintenance (cleaning)
- Fissure sealants
- Topical application of fluoride, including fluoride varnishes
- Space maintainers

**Limitations**

- Any type of prophylaxis (cleaning) or periodontal maintenance (cleaning)* is covered twice in a calendar year (refer to Class II Periodontics for additional limitation information).

**Note**: Under certain conditions of oral health, periodontal maintenance and/or prophylaxis *may be* covered up to a total of four times in a calendar year. *These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.*

- Application of fluoride is covered twice in a calendar year.
- Fissure sealants:
  - Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface.
  - The application of fissure sealants is a covered dental benefit once in a two-year period per tooth from the date of service.
- Replacement of a space maintainer previously paid for by the plan is not a paid covered benefit.
- Space maintainers are covered once in the patients lifetime for the same missing tooth or teeth

**Exclusions**

- Plaque control program, oral hygiene instruction, dietary instruction and home fluoride kits.

## Periodontics

**Covered Dental Benefits**

- Prescription-strength fluoride toothpaste.
- Antimicrobial mouth rinse.

**Limitations**

- Prescription-strength fluoride toothpaste and antimicrobial mouth rinse is a Covered Benefit following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- Proof of a periodontal procedure must accompany the claim or the patient's WDS history must show a periodontal procedure within the past 180 days.
- Antimicrobial mouth rinse is covered once per periodontal treatment.
- Antimicrobial mouth rinse is available for women during pregnancy without periodontal procedure.

****Refer Also To General Limitations and Exclusions****

## Class II Benefits

**Note:** *The subscriber should consult the provider regarding any charges that may be the patient's responsibility before treatment begins.*

**Note***:* *Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.*

### Sedation

**Covered Dental Benefits**

- General anesthesia when administered by a licensed Dentist or other WDS-approved Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.
- Intravenous sedation when administered by a licensed Dentist or other WDS-approved Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

**Limitations**

- General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS, or when medically necessary for children through age six and physically or developmentally disabled individuals when in conjunction with Class I, II, III, TMJ or optional (see Signature Page for coverage) Orthodontic Covered Dental Benefits.
- Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS.
- Either general anesthesia or intravenous sedation (but not both) are covered when performed on the same day.
- General anesthesia or intravenous sedation for routine post-operative procedures is Not a Covered Benefit.

### Palliative Treatment

**Covered Dental Benefits**

- Palliative treatment for pain.

**Limitations**

- Postoperative care and treatment of routine post-surgical complications is included in the initial cost for surgical treatment if performed within 30 days.

## Restorative Services

### Covered Dental Benefits

- Amalgam restorations (fillings) and, in anterior (front) teeth, resin-based composite or glass ionomer restorations for the following reasons:
  - Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
  - Fracture resulting in significant loss of tooth structure (missing cusp).
  - Fracture resulting in significant damage to an existing restoration.
- Resin-based composite or glass ionomer restorations placed in the buccal (facial) surface of bicuspids.
- Stainless steel crowns.

### Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
- If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except on bicuspids as noted above), it will be considered as a cosmetic procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made, with any difference in cost being the responsibility of the Eligible Person.
- Stainless steel crowns are covered once in a two-year period from the date of service.
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a paid covered benefit.
- Refer to Class III Restorative if teeth are restored with crowns, veneers, inlays or onlays.

### Exclusions

- Overhang removal
- Copings
- Recontouring or polishing of restoration

## Oral Surgery

### Covered Dental Benefits

- Major and minor oral surgeries that include the following general categories:
  - Removal of teeth
  - Preprosthetic surgery
  - Treatment of pathological conditions
  - Traumatic facial injuries
  - Preparation of the mouth for insertion of denture (vestibuloplasty).

### Exclusions

- Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth.
- Tooth transplants.
- Materials placed in extraction sockets for the purpose of generating osseous filling.

## Periodontic Services

### Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth including:
  - Examinations
  - Periodontal scaling/root planing
  - Limited adjustments to occlusion (eight teeth or less)
  - Periodontal surgery
  - WDS approved locally applied antimicrobial agents.

**Note:** *Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered benefit. A predetermination is not a guarantee of payment.*

**Limitations**

- Examinations are covered twice in a calendar year.
- Periodontal scaling/root planing per site is covered once in a three-year period from the date of service.
- Osseous surgery (per site), gingival flap surgery (per site), soft tissue grafts (per site) are covered once in a three-year period from the date of service.
- Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- Localized delivery of antimicrobial agents approved by WDS is a covered benefit under certain conditions of oral health when performed at the suggested regimen for that therapy.
- Localized delivery of antimicrobial agents approved by WDS are a covered benefit under certain conditions of oral health.
- Localized delivery of antimicrobial agents is limited to two teeth per quadrant and covered up to two times (per tooth) in a benefit period.
- Periodontal surgery and localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of six weeks and a maximum of six months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.
- Locally applied antibiotics are not a paid covered benefit when used for the purpose of maintaining non-covered dental procedures or implants.
- Refer to Class III Periodontics for benefits and limitations on complete occlusal equilibration and occlusal guard (nightguard).

### Endodontics

**Covered Dental Benefits**

- Procedures for pulpal and root canal treatment, including pulp exposure treatment, pulpotomy and apicoectomy.

**Limitations**

- Root canal treatment on the same tooth is covered only once in a two-year period from the date of service.
- Re-treatment of the same tooth is allowed when performed by a different dental office.
- Refer to Class III Prosthodontics if the root canals are placed in conjunction with a prosthetic appliance.

**Exclusions**

- Bleaching of teeth.

****Refer Also To General Limitations and Exclusions****

## Class III Benefits

**Note***:* *The subscriber should consult the provider regarding any charges that may be the patient's responsibility before treatment begins.*

**Note***:* *Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.*

### Periodontic Services

**Covered Dental Benefits**

- Under certain conditions of oral health, services covered are:
  - Occlusal guard (nightguard)
  - Repair and relines of occlusal guard (nightguard)
  - Complete occlusal equilibration.

**Note**: *These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered benefit. A predetermination is not a guarantee of payment.*

**Limitations**

- Occlusal guard (nightguard) is covered once in a three-year period from the date of service.
- Repair and relines done more than six months after the initial placement are covered.
- Complete occlusal equilibration is covered once in a lifetime.

## Restorative Services

**Covered Dental Benefits**

- Crowns, veneers, or onlays (whether they are gold, porcelain, WDS-approved gold substitute castings [except laboratory processed resin] or combinations thereof), for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or resin-based composite.
- Crown buildups
- Post and core

**Limitations**

- Crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays on the same teeth are covered once in a seven-year period from the seat date.
- If a tooth can be restored with a filling material such as amalgam or resin-based composite, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided.
- WDS will allow the appropriate amount for an amalgam or resin-based composite (tooth-colored material) restoration toward the cost of another material of higher cost.
- Payment for crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays shall be paid upon the seat date.
- Crown buildups are covered once in a seven-year period from the date of service.
    - Crown buildups are a covered benefit when more than 50 percent of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
    - A crown buildup for the purpose of improving tooth form, filling in undercuts, or reducing bulk in castings is considered basing materials and is Not a Covered Benefit.
- Post and core are covered once in a seven-year period on the same tooth from the date of service.
- A crown buildup or post and core is Not a Paid Covered Benefit within two years of a restoration on the same tooth from the date of service.
- A crown used for purposes of recontouring, repositioning a tooth to provide additional retention for a removable partial denture is not a paid covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.
- Crowns and/or onlays are not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present.
- Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a paid covered benefit.
- *For inlays Refer to Class II restorative limitations*

**Exclusions**

- Copings.

## Prosthodontic Services

### Covered Dental Benefits

- Dentures
- Fixed partial dentures (fixed bridges)
- Inlays when used as an retainer for a fixed partial denture (bridge)
- Removable partial dentures.
- Adjustment or repair of an existing prosthetic device.
- Surgical placement or removal of implants or attachments to implants.

### Limitations

- Replacement of an existing prosthetic device is covered only once every seven years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge) and removable partial dentures shall be paid upon the delivery date.
- Replacement of implants and superstructures is covered only after seven years have elapsed from any prior provision of the implant.
- Crowns and copings in conjunction with overdentures are not a paid covered benefit.
- Implant maintenance procedures, including:
    - Removal of prosthesis
    - Cleansing of prosthesis and abutments
    - Reinsertion of prosthesis
- **Full, immediate and overdentures** — The plan will allow the appropriate amount for a complete, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.
- Root canal treatment performed in conjunction with overdentures is limited to two teeth per arch and is paid at the Class III Payment Level.
- **Temporary/interim dentures** — The plan will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
- **Partial dentures** — If a more elaborate or precision device is used to restore the case, the plan will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.
- **Denture adjustments and relines** — Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service.

### Exclusions

- Duplicate dentures
- Personalized dentures
- Maintenance or cleaning of a prosthetic device or appliance, except for implant maintenance
- Copings.

## Orthodontia Benefits

*It is strongly suggested that orthodontic treatment plan be submitted to, and a predetermination be made by, WDS prior to commencement of treatment. This will allow you to know in advance what procedures may be covered, the amount WDS may pay toward the treatment and your expected financial responsibility. A predetermination is not a guarantee of payment. Additionally, payment for orthodontia is based upon eligibility. If individuals become ineligible prior to the subsequent payment of benefits, subsequent payment is not covered.*

Orthodontic treatment is defined as the necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

The lifetime maximum amount payable for orthodontic benefits rendered to an eligible person is $1,750. Not more than $875 of the maximum, or one-half of the plan's total responsibility, shall be payable for treatment during the “construction phase.”

The remaining plan payments shall be made in monthly increments until completion, up to the plan maximum, providing the employee is eligible and the dependent meets eligibility requirements . The plan will not pay for treatment if claim forms are submitted more than 12 months after banding date.

The amount payable for orthodontic treatment shall be 50 percent of the lesser of the maximum allowable fees or the fees actually charged.

**Covered Dental Benefits**

- Treatment of malalignment of teeth and/or jaws. Orthodontic records: Exams (initial, periodic, comprehensive, detailed and extensive), X-rays (intraoral, extraoral, diagnostic radiographs, panoramic), diagnostic photographs, diagnostic casts (study models) or cephalometric films.

**Limitations**

- Payment is limited to:
  - Completion, or through age 26 for eligible dependent children, whichever occur first.
  - Treatment received after coverage begins (claims must be submitted to WDS within 12 months of the start of coverage). For orthodontia claims, the initial banding date is the treatment date considered in the timely filing.
- Treatment that began prior to the start of coverage will be prorated:
  - Payment is made based on the balance remaining after the down payment and charges prior to the date of eligibility are deducted.
  - WDS will issue payments based on our responsibility for the length of the treatment. The payments are issued providing the employee is eligible and the dependent is in compliance with the age limitation.
- In the event of termination of the treatment plan prior to completion of the case or termination of this program, no subsequent payments will be made for treatment incurred after such termination date.

**Exclusions**

- Charges for replacement or repair of an appliance.
- No benefits shall be provided for services considered inappropriate and unnecessary, as determined by WDS.

****Refer Also To General Limitations and Exclusions****

## Temporomandibular Joint Treatment

*It is strongly suggested that Temporomandibular Joint Treatment (TMJ) be submitted to, and predetermination made by, WDS prior to commencement of treatment. This will allow you to know in advance what procedures may be covered, the amount WDS may pay toward the treatment and your expected financial responsibility. A predetermination is not a guarantee of payment.*

TMJ treatment is defined as nonsurgical intra-oral services provided by a licensed dentist or physician, when appropriate according to the standards of generally accepted dental practice, for the treatment of dental symptoms associated with the malfunction of the temporomandibular joint, including myofacial pain dysfunction. These procedures include:

- TMJ examination
- X-rays (TMJ film and arthrogram)
- Temporary repositioning splint
- Occlusal guard (nightguard)
- Removable metal overlay stabilizing appliance
- Fixed stabilizing appliance
- Full mouth occlusal equilibration
- Arthrocentesis

- Manipulation under local anesthesia

In addition to the limitations and exclusions set forth in this booklet, the following also apply to TMJ benefits:

1. The plan shall not pay for the repair or replacement of any appliance furnished in whole or in part for temporomandibular joints.
2. The plan shall not cover services that would normally be provided under medical care, including, but not limited to, psychotherapy, special joint exams and X-rays, joint surgery and medications.
3. Fixed appliances and restorations are not covered.
4. With the exception of procedures listed above, diagnostic procedures not otherwise covered under the plan are not covered herein.
5. Any procedures that are performed in conjunction with TMJ services, and are covered benefits under another portion of the dental plan, are not covered under this portion.

****Refer Also To General Limitations and Exclusions****

### Orthognathic Surgery

*It is strongly suggested that orthognathic treatment be submitted to, and predetermination made by, WDS prior to commencement of treatment. This will allow you to know in advance what procedures may be covered, the amount WDS may pay toward the treatment and your expected financial responsibility. A predetermination is not a guarantee of payment.*

Orthognathic treatment is defined as the necessary surgical procedures of treatment, performed by a licensed dentist or physician, to correct the malposition of the maxilla (upper jaw bone) and/or the mandible (lower jaw bone).

The amount payable for orthognathic treatment shall be 70 percent of the lesser of the maximum allowable fees or the fees actually charged.

In addition to the limitations and exclusions set forth in this booklet, the following also apply to orthognathic treatment:

**Limitations**

- Complications will be covered only if treatment is sought within 30 days from the original treatment.

**Exclusions**

- The plan shall not cover:
  - Services that would be provided under medical care including, but not limited to, hospital and professional services.
  - Diagnostic procedures not otherwise covered under this plan.
  - Any procedures that are performed in conjunction with orthognathic surgery services, and are covered benefits under another portion of the dental plan.

****Refer Also To General Limitations and Exclusions****

## General Limitations

1. Dentistry for cosmetic reasons is not a paid covered benefit. Cosmetic services include, but are not limited to, laminates, veneers or tooth bleaching.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth are not a paid covered benefit.
3. General anesthesia, intravenous, and inhalation sedation are not a paid covered benefit except that coverage will be provided a) when in conjunction with covered oral surgery, endodontic and periodontal surgical procedures; and b) for general anesthesia/intravenous (deep) sedation services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary because the enrollee is under the age of seven, or physically or developmentally disabled.

## General Exclusions

In addition to the specific exclusions and limitations stated elsewhere in this booklet, Uniform Dental Plan (UDP) does not provide benefits for:

1. Application of desensitizing medicaments.
2. Services or supplies that the Uniform Dental Plan determines are experimental or investigative. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation.
3. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as premedication and nitrous oxide.
4. Hospital or other facility care for dental procedures, including physician services and additional fees charged by the dentist for hospital treatment. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:
   a. A hospital setting for the dental care must be medically necessary.
   b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.
   c. Prior to hospitalization, a request for predetermination of dental treatment performed at a hospital is submitted to and approved by WDS. Such request for predetermination must be accompanied by a physician's statement of medical necessity.

   If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those performed by a participating dental provider, up to the available benefit maximum.
5. Dental services started prior to the date the person became eligible for services under this plan, except as provided for orthodontic benefits.
6. Services for accidental injury to natural teeth when evaluation of treatment and development of a written plan is performed more than 30 days from the date of injury. Treatment must be completed within the time frame established in the treatment plan unless delay is medically indicated and the written treatment plan is modified.
7. Expenses incurred after termination of coverage, except expenses for:
   a. Prosthetic devices that are fitted and ordered prior to termination and delivered within 30 days after termination.
   b. Crowns, if the tooth is prepared prior to termination and the crown is seated on the tooth within 30 days after termination.
   c. Root canal treatment, if the tooth canal is opened prior to termination and treatment is completed within 30 days after termination.
8. Missed appointments.
9. Completing insurance forms or reports, or for providing records.
10. Habit-breaking appliances, except as specified under the orthodontia benefit.
11. Full-mouth restoration or replacement of sound fillings. (Replacement of sound fillings will not be covered unless at the recommendation of a licensed dentist, and predetermination is required.)
12. Charges for dental services performed by anyone who is not a licensed dentist, registered dental hygienist, denturist or physician, as specified.
13. Services or supplies that are not listed as covered.
14. Treatment of congenital deformity or malformations.
15. Replacement of lost or broken dentures or other appliances.
16. Services for which an enrollee has contractual right to recover cost, whether a claim is asserted or not, under automobile, medical, personal injury protection, homeowners or other no-fault insurance.
17. In the event an Eligible Person fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.

*Washington Dental Service shall determine whether services are covered dental benefits in accordance with standard dental practice and the general limitations and exclusions shown in the Contract. Should there be a disagreement regarding the interpretation of such benefits; the subscriber shall have the right to appeal the determination in accordance with the non-binding appeals process in this contract and may seek judicial review of any denial of coverage of benefits.*

## Eligibility

Eligibility for Public Employees Benefits Board (PEBB) benefits is based on rules in Washington Administrative Code (WAC). PEBB rules are codified in chapter 182-12 WAC and are accessible through the PEBB Rules and Policies section on the PEBB website at www.pebb.hca.wa.gov.

Employees (referred to in this book as “employees,” “subscribers” or “enrollees”) are eligible for enrollment in PEBB dental plans as described in the PEBB eligibility rules in chapter 182-12 WAC.

Retired or permanently disabled employees (referred to in this book as “retirees,” “subscribers” or “enrollees”) of state government, higher education, participating K-12 school districts, educational service districts and participating employer groups are eligible for enrollment in PEBB dental plans in accordance with PEBB rules in chapter 182-12 WAC. Retiree and surviving dependent dental enrollment is contingent upon enrollment in a PEBB medical plan.

Surviving dependents (referred to in this book as “subscribers” or “enrollees”) who meet eligibility criteria are eligible for enrollment in PEBB dental plans in accordance with PEBB rules in chapter 182-12 WAC. Surviving dependents will lose their right to enroll in PEBB coverage if they do not apply to enroll or defer coverage within the timelines stated in PEBB rules or do not maintain continuous comprehensive employer-sponsored health plan coverage during a deferral.

Eligibility criteria for surviving dependents of an eligible employee or an eligible retiree are outlined in WAC 182-12-265. Eligibility criteria for surviving dependents of emergency service personnel who are killed in the line of duty are outlined in WAC 182-12-250.

To be enrolled in a health plan, a dependent must be eligible under WAC 182-12-260 and the subscriber must comply with enrollment procedures outlined in WAC 182-12-262.

The PEBB program verifies the eligibility of all dependents and reserves the right to request documents from subscribers that provide evidence of a dependent's eligibility. The PEBB Program will remove a subscriber's enrolled dependents from health plan enrollment if the PEBB Program is unable to verify a dependent's eligibility within a specified time.

The following are eligible as dependents under the PEBB eligibility rules:

1. Lawful spouse.

2. Effective January 1, 2010, Washington State-registered domestic partners, as defined in RCW 26.60.020(1).

3. Children. Children are defined as the subscriber's biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the subscriber's Washington State-registered domestic partner, or children specified in a court order or divorce decree. In addition, children include extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's Washington State-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state Department of Social and Health Services foster care program.

Eligible children include:

a. Children up to age 26.

b. Effective January 1, 2011, children of any age with disabilities, mental illness, or intellectual or other developmental disabilities who are incapable of self-support, provided such condition occurs before age 26.

- The subscriber must provide evidence of the disability and evidence that the condition occurred before age 26.
- The subscriber must notify the PEBB Program, in writing, no later than 60 days after the date that a child age 26 or older no longer qualifies under this eligibility. For example, children who become self-supporting are not eligible as of the last day of the month in which they become capable of self-support.
- Children age 26 and older who become capable of self-support do not regain eligibility under these criteria if they later become incapable of self-support.
- The PEBB Program will certify the eligibility of children with disabilities periodically.

4. Parents.

a. Parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:

- The parent maintains continuous enrollment in a PEBB medical plan;
- The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
- The subscriber continues enrollment in PEBB insurance coverage; and
- The parent is not covered by any other group medical plan.

b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not add additional dependents to their insurance coverage.

## Enrollment

PEBB enrollment rules are described in chapters 182-08 and 182-12 WAC. These rules can be found in the PEBB Rules and Policies section of the PEBB website at www.pebb.hca.wa.gov.

A subscriber or subscriber's dependent is eligible to enroll in only one PEBB dental plan even if eligibility criteria are met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two or more parents employed by PEBB participating employers may be enrolled as a dependent under one parent, but not more than one.

Employees are required to enroll in a dental plan under their employing agency. Employees must submit an Employee Enrollment/Change form no later than 31 days after the date the employee becomes eligible for PEBB benefits. If the employee does not meet this requirement, the employee will be enrolled in the Uniform Dental Plan and any eligible dependents cannot be enrolled until the next open enrollment.

Retirees and surviving dependents may enroll in dental. If a retiree or surviving dependent chooses to enroll in a dental plan, at retirement or during an open enrollment, the retiree or surviving dependent must maintain dental coverage for no less than two years, and any dependents enrolled on the subscriber's account will be enrolled in dental as well. The retiree or surviving dependent must return the appropriate enrollment form(s), as instructed on the form, within the time limits required in PEBB rules. (See WAC 182-12).

Subscribers must submit the appropriate forms within the time frames described in PEBB rules. Employees submit the appropriate forms to their employing agency. All other subscribers submit the appropriate forms to the PEBB Program. In addition to the appropriate forms indicating dependent enrollment, the PEBB Program may require the subscriber to provide documentation or evidence of eligibility or evidence of the event that created the special open enrollment.

If a subscriber wants to enroll their eligible dependent(s) when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the appropriate forms that the subscriber submits within the relevant time frame described in WAC 182-08-197, 182-12-171, or 182-12-250.

If a subscriber wants to make an enrollment change during the annual open enrollment, the subscriber must submit the appropriate forms no later than the last day of the annual open enrollment.

A subscriber may make an enrollment change outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependent (or both).

Exception: A retiree or surviving dependent may cancel a dependent's enrollment at any time. Surviving dependents of emergency service personnel may not add newly acquired dependents. Retirees or survivors who have deferred their PEBB retiree insurance coverage may only enroll as described in WAC 182-12-200, WAC 182-12-205 or WAC 182-12-250.

The following events create a special open enrollment:

1. Subscriber's dependent becomes eligible under PEBB rules:
    a. through marriage or registering a domestic partnership with Washington's Secretary of State,
    b. through birth, adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption,
    c. through legal custody or legal guardianship, or
    d. when a child becomes eligible as an extended dependent;
2. Subscriber's dependent no longer meets PEBB eligibility criteria because:
    a. subscriber has a change in marital status or Washington State-registered domestic partnership status, including legal separation documented by a court order;
    b. a child dependent turns age 26;
    c. a child dependent ceases to be eligible as an extended dependent or as a dependent with disabilities; or
    d. a dependent dies;
3. Subscriber or a dependent loses coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
4. Subscriber or a dependent has a change in employment status that affects the subscriber's or a dependent's eligibility for group health coverage or the employer contribution toward insurance coverage;
5. Subscriber or a dependent has a change in residence that affects health plan availability;
6. Subscriber receives a court order or medical support order requiring the subscriber, the subscriber's spouse, or the subscriber's Washington State-registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former registered domestic partner is not an eligible dependent);
7. Subscriber or a dependent becomes eligible for a medical assistance program under the Department of Social and Health Services, including Medicaid or the Children's Health Insurance Program (CHIP), or the subscriber or a dependent loses eligibility in a medical assistance program.

To make an enrollment change during a special open enrollment, the subscriber must submit the appropriate forms no later than 60 days after the event that creates the special open enrollment, except as provided for newborns and newly adopted children as stated below:

If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB Program by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the subscriber must submit the appropriate enrollment form no later than 12 months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

Subscribers are required to remove dependents within 60 days of the date the dependent no longer meets the eligibility criteria in WAC 182-12-250 or 182-12-260. The PEBB Program will remove a subscriber's enrolled dependent the last day of the month in which the dependent ceases to meet the eligibility criteria. Consequences for not submitting notice within 60 days of any dependent ceasing to be eligible may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-270;
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

## When Coverage Begins

For an employee and the employee's eligible dependent, enrolled when the employee is newly eligible, dental plan enrollment will begin when the employee's insurance coverage begins as described in WAC 182-12-114. PEBB dependent eligibility is defined in WAC 182-12-260 and dependent enrollment requirements are described in WAC 182-12-262.

Retiring or permanently disabled employees and surviving dependents must meet the procedural and eligibility requirements in chapter 182-12 WAC, which require the employee to submit the appropriate enrollment form(s), as instructed on the forms, to enroll in or defer enrollment in PEBB retiree insurance coverage within 60 days after their employer paid or COBRA coverage ends.

Eligible retirees who are enrolling in a PEBB health plan after deferring coverage should refer to WAC 182-12-200 and 182-12-205 for coverage effective dates. For eligible dependents, dental coverage begins on the first day of the month in which the retiree or survivor's dental coverage begins if the retiree or survivor lists the dependent on the enrollment form and the dependent meets PEBB eligibility criteria.

For an enrollee enrolled in accordance with PEBB rules during the annual open enrollment, dental coverage will begin on January 1 of the upcoming year.

For an enrollee enrolled in accordance with PEBB rules during a special open enrollment, dental coverage will begin the first of the month following the event that created the special open enrollment or, in cases where the event occurs on the first day of the month, dental coverage will begin on that date.

Exceptions:

- If adding a child due to birth or adoption (or a subscriber assuming a legal obligation for total or partial support in anticipation of adoption), health plan coverage will begin on the day the child is born or adopted. If adding a dependent other than the child, such as a spouse, then coverage begins the first of the month in which the event occurs.
- For a child with disabilities enrolled in accordance with PEBB rules, dental coverage begins on the first day of the month that eligibility is certified by the PEBB Program.

## Changing Dental Plans

Subscribers may change health plans at the following times:

During annual open enrollment: Subscribers may change health plans during the annual open enrollment.

During a special open enrollment: Subscribers may change health plans outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under Internal Revenue Code (IRC) and correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependents or both. The following events create a special open enrollment:

1. Subscriber's dependent becomes eligible under PEBB rules:
    a. through marriage or registering a domestic partnership with Washington's Secretary of State,
    b. through birth, adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption,
    c. through legal custody or legal guardianship, or
    d. when a child becomes eligible as an extended dependent;
2. Subscriber's dependent no longer meets PEBB eligibility criteria because:
    a. subscriber has a change in marital status or Washington State-registered domestic partnership status, including legal separation documented by a court order;
    b. a child dependent turns age 26;
    c. a child dependent ceases to be eligible as an extended dependent or as a dependent with disabilities; or
    d. a dependent dies;
3. Subscriber or a dependent loses coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
4. Subscriber or a dependent has a change in employment status that affects the subscriber's or a dependent's eligibility for group health coverage or the employer contribution toward insurance coverage;
5. Subscriber or a dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location but the subscriber does not select a new health plan, the PEBB Program may enroll the subscriber in the Uniform Medical Plan or Uniform Dental Plan;
6. Subscriber receives a court order or medical support order requiring the subscriber, the subscriber's spouse, or the subscriber's Washington State-registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former registered domestic partner is not an eligible dependent);
7. Subscriber or a dependent becomes eligible for a medical assistance program under the Department of Social and Health Services, including Medicaid or the Children's Health Insurance Program (CHIP), or the subscriber or a dependent loses eligibility under a medical assistance program;
8. Seasonal employees whose off-season occurs during the annual open enrollment. They may select a new health plan upon their return to work;
9. Subscriber or an eligible dependent becomes entitled to Medicare, enrolls in or disenrolls from a Medicare Part D plan;
10. Subscriber experiences a disruption that could function as a reduction in benefits for the subscriber or the subscriber's dependent(s) due to a specific condition or ongoing course of treatment. A subscriber may not change their health plan if the subscriber's or an enrolled dependent's physician stops participation with the subscriber's health plan unless the PEBB program determines that a continuity of care issue exists.

NOTE: If an enrollee's dentist or other dental practitioner discontinues participation in an enrollee's plan, the enrollee may not change plans until the next open enrollment period, except as provided in WAC 182-08-198(2). Also, if an enrollee transfers from one agency or school to another during the plan year, the enrollee is not permitted to change plans, except as outlined above.

See the Enrollment section in this booklet for details on where to submit forms.

## When Coverage Ends

Coverage ends on the earliest of the following dates:

1. For any individual who ceases to be eligible for PEBB insurance, coverage ends on the last day of the month in which eligibility ends.
2. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB plan.
3. For an enrollee who declines the opportunity or is ineligible to continue enrollment in a PEBB plan under one of the options for continuing PEBB benefits described in this certificate of coverage, medical coverage ends for the enrollee at midnight on the last day of the month in which he or she ceases to be eligible.
4. If the subscriber stops paying monthly premiums, coverage ends for the subscriber and enrolled dependents on the last day of the month for which the last full premium was paid. A full month's premium is charged for each calendar month of coverage. Premium payments are not prorated if an enrollee dies or cancels his or her coverage before the end of the month.

When dental plan enrollment ends, the enrollee may be eligible for continuation of coverage if application is made within the time limits explained in the Continuing Benefits sections of this booklet.

The enrollee is responsible for timely payment of premiums and reporting changes in eligibility or address.

As a PEBB plan enrollee it is the enrollee's responsibility to pay premiums when due. If the enrollee's coverage is canceled due to delinquency, the enrollee's eligibility to participate in PEBB benefits will end.

Failure to report changes can result in loss of premiums and loss of the enrollee and his or her dependents' right to continue coverage under the federal COBRA law or PEBB rules. If you need assistance in obtaining the proper form for communicating changes to the PEBB Program, please call PEBB Customer Service staff at 1-800-200-1004.

## Options for Continuing Benefits

Subscribers and their dependents covered by this dental plan may be eligible to continue enrollment during temporary or permanent loss of eligibility. There are four continuation coverage options you may be eligible for as a PEBB enrollee:

- COBRA
- PEBB Extension of Coverage
- Leave Without Pay (LWOP) Coverage
- PEBB retiree insurance coverage

The first three options temporarily extend group insurance coverage if certain circumstances occur that would otherwise end your or your dependent's PEBB medical plan and dental plan coverage. COBRA coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative that may be appropriate in specific situations.

The fourth option above is only available to individuals who meet eligibility and procedural requirements defined in Washington Administrative Code (WAC) 182-12-171 or surviving dependents who meet eligibility requirements defined in WAC 182-12-250 or 182-12-265. These rules are accessible through the PEBB Rules and Policies section of the PEBB website www.pebb.hca.wa.gov.

All four options are administered by the PEBB Program. Refer to your PEBB Initial Notice of COBRA and Continuation Coverage Rights booklet for specific details or call the PEBB Program Customer Service at 1-800-200-1004.

## Family and Medical Leave Act of 1993

Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive up to 26 weeks of employer-paid medical, dental, basic life, and basic long-term disability insurance. The employee's employing agency is responsible for determining if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay the employee premium contribution during this period to maintain eligibility. After that, insurance coverage may be continued as explained in the section titled "Employees and Dependents Options for Continuing PEBB Benefits."

## Payment of Premium During a Labor Dispute

Any employee or dependent whose monthly premiums are paid in full or in part by the employer may pay premiums directly to this dental plan or the HCA if the employee's compensation is suspended or canceled directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the employee's compensation is suspended or canceled, the employee shall be notified immediately by the HCA, in writing, by mail sent to the last address of record with the HCA, that the employee may pay premiums as they become due as provided in this section.

## Appealing a Determination of Ineligibility for Insurance Coverage

Any employee, retiree, survivor, or Dependent who disagrees with a decision regarding eligibility for PEBB insurance coverage may request reconsideration of the decision. Guidance on filing an eligibility appeal may be obtained in chapter 182-16 WAC (which governs PEBB eligibility appeals), on PEBB's website under "How Do I" (www.pebb.hca.wa.gov), or by calling the PEBB Appeals Manager through the PEBB Program customer service phone line at 1-800-200-1004.

## Relationship to Law and Regulations

The language of this Certificate of Coverage (COC) is based on the rules that administer the HCA's PEBB Program in chapters 182-08, 182-12, 182-16 WAC. In the case of a conflict between the rules and the language describing eligibility and enrollment in this COC, the rules shall govern. This agreement between the HCA and the contracted vendor for benefits shall be interpreted, administered, and enforced according to the laws and regulations of the state of Washington, except as preempted by federal law.

## Release of Information

Enrollees may be required to provide the Uniform Dental Plan or the HCA with information necessary to determine eligibility, administer benefits or process claims. This could include, but is not limited to, dental records. Coverage could be denied if enrollees fail to provide such information when requested.

## Third Party Liability

## (Subrogation/Reimbursement)

Benefits of the Uniform Dental Plan will be available to an enrollee who is injured or becomes ill because of a third party's action or omission. The Uniform Dental Plan shall be subrogated to the rights of the enrollee against any third party liable for the illness or injury. Subrogation means that the Uniform Dental Plan (1) shall be entitled to reimbursement from any recovery by the enrollee from the liable third party, and (2) shall have the right to pursue claims for damages from the party liable for the injury or illness. The Uniform Dental Plan's subrogation rights shall extend to the full amount of benefits paid by the Uniform Dental Plan for such an illness or injury. As a condition of receiving benefits for such an illness or injury, the enrollee, and his or her representatives, shall cooperate fully with the Uniform Dental Plan in recovering the amounts it has paid including, but not limited to:

(a) providing information to the Uniform Dental Plan concerning the facts of the illness or injury and the identity and address of the third party or parties who may be liable for the illness or injury, their liability insurers, and their attorneys; (b) providing reasonable advance notice to the Uniform Dental Plan of any trial or other hearing, or any intended settlement, or a claim against any such third party; and (c) repaying the Uniform Dental Plan from the proceeds of any recovery from or on behalf of any such third party.

### Enrollee's Obligation to Notify the Uniform Dental Plan

Enrollees must notify the Uniform Dental Plan of any claim or lawsuit for a condition or injury for which the Uniform Dental Plan paid benefits. This includes promptly notifying the Uniform Dental Plan in writing of all the following matters:

- The facts of the enrollee's condition or injury,
- Any changes in the enrollee's condition or injury,
- The name of any person responsible for the enrollee's condition or injury and that person's insurance carrier, and
- Advance notice of any settlement the enrollee intends to make of the action or claim.

### Right of Recovery

If an enrollee brings a claim or lawsuit against another person, the enrollee must also seek recovery of any benefits paid under this plan; the Uniform Dental Plan reserves the right to join as a party in any lawsuit the enrollee brings. The Uniform Dental Plan may, however, assert a right to recover benefits directly from the other person or from the enrollee. If the Uniform Dental Plan does so, the enrollee does not need to take any action on behalf of the Uniform Dental Plan. The enrollee must, however, do nothing to impede the Uniform Dental Plan's right of recovery. Should the Uniform Dental Plan assert its right of recovery directly, it has the right to join the enrollee as a party in the action or claim.

If the enrollee obtains a settlement or recovery for less than the insurance policy limits or reachable assets of the liable party, the enrollee is obligated to reimburse the Uniform Dental Plan for the full amount of benefits paid on the enrollee's behalf. If, however, the enrollee obtains a settlement or recovery that is equal to or greater than the liable party's insurance policy limits or assets, the enrollee is only obligated to reimburse the Uniform Dental Plan in the amount that is left after the enrollee has been fully compensated.

Any person who is obligated to pay for services or supplies for which benefits have been paid by the Uniform Dental Plan must pay to the Uniform Dental Plan the amounts to which the Uniform Dental Plan is entitled.

## Coordination/Non-Duplication of Benefits

Coordination of This Contract's Benefits with Other Benefits: The coordination of benefits (COB) provision applies when you have dental coverage under more than one *Plan*. *Plan* is defined below.

The UDP employs a coordination of benefits method known as non-duplication of benefits when it is secondary to another group plan. This means that when the UDP is secondary it will pay no more than the amount it would have paid if it were the primary plan, minus what the primary plan has paid.

The UDP will coordinate benefit payments with any other group dental plan or Workers' Compensation plan which covers the enrollee. Benefit payments will not be coordinated with any individual coverage the enrollee has purchased.

If the enrollee is covered by more than one group dental insurance plan, please submit claims to WDS and the other carriers at the same time. This helps to coordinate benefits more quickly.

The plan that is to provide benefits first will do so for all the expenses allowed under its coverage. The other plan will then provide benefits for the remaining allowed expenses.

The order of benefit determination rules govern the order in which each *Plan* will pay a claim for benefits. The *Plan* that pays first is called the *Primary Plan*. The *Primary Plan* must pay benefits according to its policy terms without regard to the possibility that another *Plan* may cover some expenses. The *Plan* that pays after the *Primary Plan* is the *Secondary Plan*. The *Secondary Plan* may reduce the benefits it pays so that payments from all *Plan*s do not exceed 100 percent of the total *Allowable Expense*.

**Definitions:** For the purpose of this section, the following definitions shall apply:

A “***Plan***” is any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *Plan* and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate *Plan*.

- *Plan* includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), *Closed Panel Plan*s or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental *Plan*, as permitted by law.
- *Plan* does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident and similar coverage that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; A state plan under Medicaid; A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; automobile insurance policies required by statute to provide medical benefits; benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined by law or coverage under other federal governmental *Plan*s, unless permitted by law.

Each contract for coverage under the above bullet points is a separate *Plan*. If a *Plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *Plan*.

“***This Plan***” means, in a COB provision, the part of the contract providing the dental benefits to which the COB provision applies and which may be reduced because of the benefits of other *Plan*s. Any other part of the contract providing dental benefits is separate from *This Plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether *This Plan* is a *Primary Plan* or *Secondary Plan* when you have dental coverage under more than one *Plan*.

When *This Plan* is primary, it determines payment for its benefits first before those of any other *Plan* without considering any other *Plan*'s benefits. When *This Plan* is secondary, it determines its benefits after those of another *Plan* and must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plan*s for the claim are coordinated up to 100 percent of the total *Allowable Expense* for that claim. This means that when *This Plan* is secondary, it must pay the amount which, when combined with what the *Primary Plan* paid, does not exceed 100 percent of the highest *Allowable Expense*. In addition, if *This Plan* is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the *Primary Plan*) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an *Allowable Expense* under *This Plan*. If *This Plan* is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

“***Allowable Expense***” is a dental care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the *Plans* covering the you. When coordinating benefits, any *Secondary Plans* must pay an amount which, together with the payment made by the *Primary Plan*, does not exceed the higher of the allowable expenses. In no event will a *Secondary Plan* be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A and Part B or Part C are primary, Medicare’s allowable amount is the highest allowable expense. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense. The following are examples of expenses that are not *Allowable Expense*s:

- If you are covered by two or more *Plan*s that compute their benefit payments on the basis of a relative value schedule reimbursement method or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.
- If you are covered by two or more *Plan*s that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *Allowable Expense*.

"***Closed Panel Plan***" is a *Plan* that provides dental benefits to you in the form of services through a panel of providers who are primarily employed by the *Plan*, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

"***Custodial Parent***" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

**Order of Benefit Determination Rules:** When you are covered by two or more *Plan*s, the rules for determining the order of benefit payments are as follows:

The *Primary Plan* must pay or provide its benefits as if the *Secondary Plan* or *Plans* did not exist.

A *Plan* that does not contain a coordination of benefits provision that is consistent with Chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both *Plan*s state that the complying *Plan* is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the *Plan* provided by the contract holder.

A *Plan* may consider the benefits paid or provided by another *Plan* in calculating payment of its benefits only when it is secondary to that other *Plan*.

Each *Plan* determines its order of benefits using the first of the following rules that apply:

"***Non-Dependent or Dependent***:" The *Plan* that covers you other than as a *Dependent*, for example as an employee, member, policyholder, subscriber or retiree is the *Primary Plan* and the *Plan* that covers you as a *Dependent* is the *Secondary Plan*. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *Plan* covering you as a *Dependent*, and primary to the *Plan* covering you as other than a *Dependent* (e.g., a retired employee), then the order of benefits between the two *Plan*s is reversed so that the *Plan* covering you as an employee, member, policyholder, subscriber or retiree is the *Secondary Plan* and the other *Plan* is the *Primary Plan*.

"***Dependent Child Covered Under More Than One Plan:***" Unless there is a court decree stating otherwise, when a *Dependent* child is covered by more than one *Plan* the order of benefits is determined as follows:

1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
   a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
   b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   a) If a court decree states that one of the parents is responsible for the Dependent child's dental expenses or dental coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claims determination periods commencing after the Plan is given notice of the court decree;
   b) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental expenses, the Plan of the parent assuming financial responsibility is primary;
   c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;

d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or
e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:
    I. The *Plan* covering the *Custodial Parent*, first;
    II. The *Plan* covering the spouse of the *Custodial Parent*, second;
    III. The *Plan* covering the non*custodial Parent*, third; and then
    IV. The *Plan* covering the spouse of the non*custodial Parent*, last

3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

"***Active Employee or Retired or Laid-off Employee:***" The *Plan* that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the *Primary Plan*. The *Plan* covering you as a retired or laid-off employee is the *Secondary Plan*. The same would hold true if you are a *Dependent* of an active employee and you are a *Dependent* of a retired or laid-off employee. If the other *Plan* does not have this rule, and as a result, the *Plan*s do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

"***COBRA or State Continuation Coverage:***" If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another *Plan*, the *Plan* covering you as an employee, member, subscriber or retiree or covering you as a *Dependent* of an employee, member, subscriber or retiree is the *Primary Plan* and the COBRA or state or other federal continuation coverage is the *Secondary Plan*. If the other *Plan* does not have this rule, and as a result, the *Plan*s do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

"***Longer or Shorter Length of Coverage:***" The *Plan* that covered you as an employee, member, policyholder, subscriber or retiree longer is the *Primary Plan* and the *Plan* that covered you the shorter period of time is the *Secondary Plan*.

If the preceding rules do not determine the order of benefits, the *Allowable Expense*s must be shared equally between the *Plan*s meeting the definition of *Plan*. In addition, *This Plan* will not pay more than it would have paid had it been the *Primary Plan*.

**Effect on the Benefits of *This Plan*:** When *This Plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *Plan*s during a claim determination period are not more than the *Total Allowable Expense*s. In determining the amount to be paid for any claim, the *Secondary Plan* must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plan*s for the claim do not exceed 100 percent of the total *Allowable Expense* for that claim. Total *Allowable Expense* is the highest *Allowable Expense* of the *Primary Plan* or the *Secondary Plan*. In addition, the *Secondary Plan* must credit to its *Plan* deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

**How We Pay Claims When We Are Secondary:** When we are knowingly the *Secondary Plan*, we will make payment promptly after receiving payment information from your *Primary Plan*. Your *Primary Plan*, and we as your *Secondary Plan*, may ask you and/or your provider for information in order to make payment. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the *Primary Plan* fails to pay within 60 calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim for us to make payment as if we were your *Primary Plan*. In such situations, we are required to pay claims within 30 calendar days of receiving your claim and the notice that your *Primary Plan* has not paid. This provision does not apply if Medicare is the *Primary Plan*. We may recover from the *Primary Plan* any excess amount paid under the "right of recovery" provision in the plan.

- If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the *Primary Plan*, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other plans.
- We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all plans for the claim does not exceed one hundred percent of the total allowable expense (the highest of the amounts allowed under each plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the plan(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid.

**Right to Receive and Release Needed Information:** Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under *This Plan* and other *Plan*s. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *This Plan* and other *Plan*s covering you. The Company need not tell, or get the consent of, any person to do this. You, to claim benefits under *This Plan* must give the Company any facts it needs to apply those rules and determine benefits payable.

**Facility of Payment:** If payments that should have been made under *This Plan* are made by another *Plan*, the Company has the right, at its discretion, to remit to the other *Plan* the amount the Company determines appropriate to satisfy the intent of this provision. The amounts paid to the other *Plan* are considered benefits paid under *This Plan*. To the extent of such payments, the Company is fully discharged from liability under *This Plan*.

**Right of Recovery:** The Company has the right to recover excess payment whenever it has paid *Allowable Expense*s in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The Company may recover excess payment from any person to whom or for whom payment was made or any other Company or *Plan*s.

If payments that should have been made under *This Plan* are made by another *Plan*, WDS has the right, at its discretion, to remit to the other *Plan* the amount it determines appropriate. To the extent of such payments, WDS is fully discharged from liability under *This Plan*.

**Notice to covered persons** If you are covered by more than one health benefit *Plan*, and you do not know which is your *Primary Plan*, you or your provider should contact any one of the health *Plan*s to verify which *Plan* is primary. The health *Plan* you contact is responsible for working with the other health *Plan* to determine which is primary and will let you know within 30 calendar days.

**CAUTION:** All health *Plan*s have timely claim filing requirements. If you, or your provider, fail to submit your claim to a secondary health *Plan* within the *Plan*'s claim filing time limit, the *Plan* can deny the claim. If you experience delays in the processing of your claim by the primary health *Plan*, you or your provider will need to submit your claim to the secondary health *Plan* within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one *Plan* you should promptly report to your providers and *Plan*s any changes in your coverage.

In the event WDS makes payments in excess of the maximum amount, WDS shall have the right to recover the excess payments from the patient, the subscriber, the provider or the other plan.

The two examples that follow explain how non-duplication of benefits works:

**Example 1:** Assume a subscriber has satisfied the deductible on both the primary dental plan and the UDP. The individual receives services for a root canal (Class II benefit) that costs $350. The primary plan pays Class II benefits at 90% and would pay $315 ($350 x 90%). The UDP pays Class II services at 80% and would have paid $280 ($350 x 80%) if it were primary. As secondary payer, the UDP subtracts what the primary payer paid and pays the difference ($280 - $315 = $0 payment).

**Example 2:** Assume the primary plan pays 50% for Class II benefits. The primary plan would pay $175 ($350 x 50%) for the root canal described in Example 1. As secondary payer, the UDP would pay $105 ($280 - $175).

## Claim Review And Appeal

### Predetermination Of Benefits

A predetermination is a request made by your dentist to WDS to determine your benefits for a particular service. This predetermination will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services. Please be aware that the predetermination is not a guarantee of payment but strictly an estimate for services. Payment for services is determined when the claim is submitted. (Please refer to the Initial Benefits Determination section regarding claims requirements.)

A standard predetermination is processed within 15 days from the date of receipt if all appropriate information is completed. If it is incomplete, WDS may request additional information, request an extension of 15 days and pend the predetermination until all of the information is received. Once all of the information is received a determination will be made within 15 days of receipt. If no information is received at the end of 45 days, the predetermination will be denied.

### Urgent Predetermination Requests

Should a predetermination request be of an urgent nature, where a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or dentist who has knowledge of the medical condition, WDS will review the request within 72-hours from receipt of the request and all supporting documentation. When practical, WDS may provide notice of determination orally with written or electronic confirmation to follow within 72 hours. Immediate treatment is allowed without a requirement to obtain a predetermination in an emergency situation subject to the contract provisions.

### Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to WDS for payment, modification, or denial of services. In accordance with regulatory requirements, WDS processes all clean claims within 30 days from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Claims not meeting this definition are paid or denied within 60 days of receipt.

If a claim is denied, in whole or in part, or is modified, you will be furnished with a written explanation of benefits (EOB) that will include the following information:

- The specific reason for the denial or modification
- Reference to the specific plan provision on which the determination was based
- Your appeal rights should you wish to dispute the original determination

## Appeals Of Denied Claims

### Informal Review

If your claim for dental benefits has been denied, either in whole or in part, you have the right to request an informal review of the decision. Either you, or your Authorized Representative, must submit your request for a review within 180 days from the date your claim was denied (please see your Explanation of Benefits form). A request for a review may be made orally or in writing, and must include the following information:

- Your name and ID number
- The group name and number
- The claim number (from your Explanation of Benefits form)
- The name of the dentist

Please submit your request for a review to:

Washington Dental Service
Attn: Appeals Coordinator
P.O. Box 75983
Seattle, WA 98175-0983

For oral appeals, please call Uniform Dental Plan Customer Service Department at 1-800-537-3406 or 206-522-3344.

You may include any written comments, documents or other information that you believe supports your claim.

WDS will review your claim and make a determination within 30 days of receiving your request and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision.

Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

### Appeals Committee

If you are dissatisfied with the outcome of the informal review, you may request that your claim be reviewed formally by the WDS Appeals Committee. This Committee includes only persons who were not involved in either the original claim decision or the informal review.

Your request for a review by the Appeals Committee must be made within 90 days of the post-marked date of the letter notifying you of the informal review decision. Your request should include the information noted above plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeal Committee will review your claim and make a determination within 60 days of receiving your request or within 20 days for Experimental/Investigational procedure appeals and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

The decision of the Appeals Committee is final. If you disagree with this the outcome of your appeal and you have exhausted the appeals process provided by the Uniform Dental Plan, there may be other avenues available for further action. If so, these will be provided to you in the final decision letter.

### Authorized Representative

An enrollee may authorize another person to represent them and with whom they want WDS to communicate regarding specific claims or an appeal. The authorization must be in writing, signed by the enrollee, and include all the information required in an appeal. (An assignment of benefits, release of information, or other similar form that the enrollee may sign at the request of their health care provider does not make the provider an authorized representative.) The enrollee can revoke the authorized representative at any time, and enrollees can authorize only one person as their representative at a time.

## Your Rights And Responsibilities

At WDS our mission is to provide quality dental benefit products to employers and employees throughout Washington through a network of more than 3,400 participating dentists. We view our benefit packages as a partnership between WDS, our subscribers and our participating members' dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

### You have the right to:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta member / non-member), but you can receive care from any dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care dentist makes a specific referral for specialty care.
- Contact WDS customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at deltadentalwa.com
- Appeal in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

### To receive the best oral health care possible, it is your responsibility to:

- Know your benefit coverage and how it works.
- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 hours notice for appointment cancellations before they will waive service charges.
- Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- Give accurate and complete information about your health status and history and the health status and history of your family to all care providers when necessary.
- Read carefully and ask questions about all forms and documents which you are requested to sign, and request further information about items you do not understand.
- Follow instructions given by your dentist or their staff concerning daily oral health improvement or post-service care.
- Send requested documentation to WDS to assist with the processing of claims.
- If applicable, pay the dental office the appropriate co-payments amount at time of visit.
- Respect the rights, office policies and property of each dental office you have the opportunity to visit.
- Inform your dentist and your employer promptly of any change to your or a family member's address, telephone, or family status.

## HIPPA Disclosure Policy

Washington Dental Service maintains a Compliance Program which includes an element involving maintaining privacy of information as it relates to the HIPAA Privacy & Security Rule and the Gram-Leach Bliley Act. As such we maintain a HIPAA Privacy member helpline for reporting of suspected privacy disclosures, provide members a copy of our privacy notice, track any unintended disclosures, and ensure the member rights are protected as identified by the Privacy Rule.

Policies and procedures are maintained and communicated to WDS employees with reminders to maintain the privacy of our member's information. We also require all employees to participate in HIPAA Privacy & Security training through on-line education classes, email communications, and periodic auditing.

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